STATEMENT OF CARL BLAKE

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PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS,

SUBCOMMITTEE ON HEALTH

CONCERNING

H.R. 92, THE "VETERANS TIMELY ACCESS TO HEALTH CARE ACT;"

H.R. 315, THE "HELP ESTABLISH ACESS TO TIMELY HEALTH CARE FOR YOUR VETS (HEALTHY VETS) ACT;"

H.R. 339, THE "VETERANS OUTPATIENT CARE ACCESS ACT;"

H.R. 463, THE "HONOR OUR COMMITMENT TO VETERANS ACT;"

H.R. 538, THE "SOUTH TEXAS VETERANS ACCESS TO CARE ACT;"

H.R. 542; H.R. 1426, THE "RICHARD HELM VETERANS' ACCESS TO LOCAL HEALTH CARE OPTIONS AND RESOURCES ACT;"

H.R. 1470, THE "CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT;"

H.R. 1471, THE "BETTER ACCESS TO CHIROPRACTORS TO KEEP OUR VETERANS HEALTHY ACT;"

H.R. 1527, THE "RURAL VETERANS ACCESS TO CARE ACT;"

AND PROPOSED LEGISLATION

APRIL 26, 2007

Mr. Chairman and members of the Subcommittee, on behalf of Paralyzed Veterans of America (PVA), I would like to thank you for the opportunity to testify today regarding the proposed legislation. We recognize that the Department of Veterans Affairs (VA) faces serious challenges as it continues to face rapidly growing demand on its health care system. It seems ironic that in the face of some criticism about the care being provided in VA facilities that the demand on the system has never been higher.

H.R. 92, THE "VETERANS TIMELY ACCESS TO HEALTH CARE ACT"

H.R. 92, the "Veterans Timely Access to Health Care Act," would establish standards of access to care within the VA health system. Under the provisions of this legislation, the VA will be required to provide a primary care appointment to veterans seeking health care within 30 days of a request for an appointment. If a VA facility is unable to meet the 30-day standard for a veteran, then the VA must make an appointment for that veteran with a non-VA provider, thereby contracting out the health care service. The legislation also requires the Secretary of the VA to report to Congress each quarter of a fiscal year on the efforts of the VA health system to meet this 30-day access standard.

Access is indeed a critical concern of PVA. The number of veterans enrolled in the VA is approaching 8 million and the number of unique users is nearly 6 million. Despite the ongoing policy to deny enrollment to Category 8 veterans, the numbers of enrolled veterans will continue to increase, particularly as more and more veterans of the Global War on Terror take advantage of the services in VA.

Unfortunately, funding for VA health care has not kept pace with the growing demand. Furthermore, Congress has failed to live up to its responsibility to provide adequate funding in a timely manner. Despite a positive funding outlook for this year, we remain skeptical. As long as VA continues to receive funding months into its fiscal year, it will never be able to properly plan to meet demand. To that end, access standards without sufficient funding provided by the start of the fiscal year are standards in name only.

PVA is concerned that contracting health care services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care. In fact, it may actually serve as a disincentive to achieve timely access for veterans seeking care. Contracting out to private providers will leave the VA with the difficult task of ensuring that veterans seeking treatment at non-VA facilities are receiving quality health care. We do think that access standards are important, but we believe that the answer to providing timely care is in providing sufficient funding in the first place in order to negate the impetus driving health care rationing. For these reasons, PVA cannot support H.R. 92.

H.R. 315, THE "HELP ESTABLISH ACESS TO TIMELY HEALTH CARE FOR YOUR VETS (HEALTHY VETS) ACT"

H.R. 1527, THE "RURAL VETERANS ACCESS TO CARE ACT"

Because, these two bills principally address the same issue, I will outline our concerns with the proposed bills in one statement. PVA is fully aware of the challenges the VA faces every day to provide timely access to quality health care for veterans who live in rural areas of the country. However, we are concerned that in addressing the problem of access for these veterans, the long-term viability of the VA health care system may be threatened. PVA members rely on the direct services provided by VA health care facilities recognizing the fact that they do not always live close to the facility. The services provided by VA, particularly specialized services like spinal cord injury care, are unmatched in the private sector. If a larger pool of veterans is sent into the private sector for health care, the diversity of services and expertise in different fields is placed in jeopardy.

Ultimately, PVA has serious concerns about the provisions of this legislation that would give VA additional leverage to broaden contracting out of health care services to veterans in geographically remote or rural areas. If you review the early stages of VA's Project HERO, it is apparent that this is a direction that some VA senior leadership would like to go. We believe that this pilot program would set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the federal government to shift its responsibility of caring for the men and women who served.

Current law limits VA in contracting for private health care services to instances in which VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. The VA could better meet the demands of rural veterans through more judicious application of its fee-for-service program.

In the end, we believe that in order for the VA to best meet this demand, adequate funding needs to be provided for VA health care in a timely manner. As we previously stated, placing the VA in the position it has dealt with for many years because Congress continues to wrangle over federal budgets, does not prepared the VA to properly meet demand, including demand in rural areas.

Finally, we realize that it is an extremely difficult task to establish a standard for when a veteran's home is considered to be rural. This legislation attempts to do so by stating defining "geographically inaccessible" in terms of a population density as it relates to a distance from a VA facility. However, this is very much a subjective idea. Access to VA health care is subject not only to population density or distance, but time as well. The difficulty in addressing this subject is apparent just by comparing the methods that the proposed bills take to define rural accessibility. However, due to the concerns that we have outlined, PVA cannot support H.R. 315 or H.R. 1527.

H.R. 339, THE "VETERANS OUTPATIENT CARE ACCESS ACT"

PVA opposes H.R. 339, the "Veterans Outpatient Care Access Act." As with the previous bills discussed, this bill would simply encourage broader contracting out of health care services without attempting to fix the problems that exist as a result of insufficient funding. With adequate resources and staffing, the challenges faced by outpatient clinics could be minimized. However, with the passage of this legislation, the VA would be discouraged from doing the right thing. For example, if a local clinic loses a particular specialty doctor, that clinic would likely turn to a contract provider without trying to refill that position.

Legislation such as this, once again, allows the federal government to absolve itself from the responsibility to care for the men and women who have served and sacrificed for this country. It is time for Congress to stop trying to pass the buck and provide the resources it will take the VA to provide this critical care. It makes no sense to continue to consider legislation that would lead veterans away from the best health care system in America.

H.R. 463, THE "HONOR OUR COMMITMENT TO VETERANS ACT"

PVA fully supports H.R. 463, the "Honor Our Commitment to Veterans Act." The provisions of this legislation are in accordance with the recommendations of *The Independent Budget*. We have continued to advocate for this policy to be overturned since it was put into place. It is unacceptable that these veterans are being denied access to health care simply because the Administration and Congress have been unwilling to provide the necessary funding to reopen the VA health care system to them. We believe this policy should be overturned and that adequate resources should be provided to overturn this policy decision.

VA estimates that more than 1.5 million category 8 veterans will have been denied enrollment in the VA health-care system by FY 2008. Assuming a utilization rate of 20 percent, in order to reopen the system to these deserving veterans, *The Independent Budget* estimates that VA will require approximately $366 million in discretionary dollars.

H.R. 538, THE "SOUTH TEXAS VETERANS ACCESS TO CARE ACT"

PVA has no official position on this legislation. We believe that this is a local access issue. If a demonstrated need is there, then the VA must develop a solution to meet the needs of the men and women in this region.

H.R. 542

PVA has no opposition to the provisions of H.R. 542. Overall, we are pleased with the direction that VA has taken and the progress it has made with respect to its mental health programs. A great deal of time and resources have been invested in the VA's mental health programs in recent years to meet the growing demand of new veterans from Operation Enduring Freedom and

Operation Iraqi Freedom (OEF/OIF). The War Supplemental currently being debated even includes significant additional resources to meet the mental health needs of OEF/OIF veterans. Many of the service members who have served in OEF/OIF have experienced mild to severe mental health problems. Our only concern is that the VA does not invest considerable resources into the requirements of this legislation if the demand for such services is not really there. However, given that we do not have specifics about this type of demand, we would simply urge the VA to proceed with caution.

H.R. 1426, THE "RICHARD HELM VETERANS' ACCESS TO LOCAL HEALTH CARE OPTIONS AND RESOURCES ACT"

PVA finds it difficult to comprehend the rationale for establishing a precedent for veterans in the VA health care system to leave that system and seek services elsewhere, as this proposed legislation would do. Over the past year we have read, as I am sure every member of Congress has, all of the accolades given to VA health care by independent observers, newsweeklies and other publications. While we believe VA represents the best available care, oversight is needed to provide an additional guarantee that VA-provided services are of the highest quality for all veterans who use VA, especially for those with service-connected disabilities.

While this legislation may be well intentioned, the potential unintended consequences far outweigh any benefit that this bill might provide. There would almost certainly be a diminution of established quality, safety and continuity of VA care if veterans were to leave the system. It is important to note that VA's specialized health care programs, authorized by Congress and designed expressly to meet the needs of combat-wounded and ill veterans, such as the blind rehabilitation centers, prosthetic and sensory aid programs, readjustment counseling, poly-trauma and spinal cord injury centers, the centers for war-related illnesses, and the national center for post-traumatic stress disorder, as well as several others, would be irreparably affected by the loss of service-connected veterans from those programs. The VA's medical and prosthetic research program, designed to study and hopefully cure the ills of disease and injury consequent to military service, would lose focus and purpose were service-connected veterans no longer present in VA health care. Additionally, Title 38, United States Code, section 1706(b)1 requires VA to maintain the capacity of these specialized medical programs, and not let their capacity fall below that which existed at the time when Public Law 104-262 was enacted.

While as a consequence of enactment of this bill some service-connected veterans might seek care in the private sector as a matter of personal convenience, they would lose the many safeguards built into the VA system through its patient safety program, evidence-based medicine, electronic medical records and medication verification program. These unique VA features culminate in the highest quality care available, public or private. Loss of these safeguards, that are generally not available in private sector systems, would equate to diminished oversight and coordination of care, and ultimately may result in lower quality of care for those who deserve it most.

With regards to the prescription drug provisions included in the legislation, P.L. 108-199, the "Consolidated Appropriations Act of 2004" provided the Secretary of VA the authority to

dispense prescription drugs from Veterans Health Administration (VHA) facilities to enrolled veterans with prescriptions written by private physicians. Included in the public law, and further explained in the Conference Report H. Rpt. 108-401, was the requirement that the VA would incur no additional cost in providing such a benefit.

VA physicians, by being the sole source of care, have been fully able to monitor patients for potentially contra-indicative prescriptions. PVA is concerned that if VA is to accept non-VA physician written prescriptions, veteran patients may be put at risk with this loss of monitoring should the patient seek treatment both inside and outside the VA health care system.

H.R. 1470, THE "CHIROPRACTIC CARE AVAILABLE TO ALL VETERANS ACT"

PVA has no opposition to H.R. 1470, the "Chiropractic Care Available to All Veterans Act." Chiropractic care is another medical service that could benefit many veterans and disabled veterans who face spinal and musculoskeletal difficulties. Currently, the VA provides chiropractic care in selected sites in accordance with P.L. 107-135, the "Department of Veterans Affairs Health Care Programs Enhancement Act of 2001." We see no problem with expanding this specialty care to the broader VA health care system; however, we must emphasize that adequate resources must be appropriated to allow VA to provide this care.

H.R. 1471, THE "BETTER ACCESS TO CHIROPRACTORS TO KEEP OUR VETERANS HEALTHY ACT"

As we previously stated, PVA has no objection to the provision of chiropractic care within the VA health care system. However, we do not support Section 3 of this legislation which would elevate chiropractors to the status of a primary care physician in the VA. The primary care provider is responsible for assessment of illness and injury and triage to the appropriate specialty care. The primary care provider also provides basic care far beyond the scope of musculoskeletal conditions and the interaction with the nervous system—the principal focus of chiropractors. We believe that chiropractic care should be provided in consultation with the primary care provider responsible for the total health care needs of the veteran.

H.R. 1944, THE "VETERANS TRAUMATIC BRAIN INJURY TREATMENT ACT"

PVA supports H.R. 1944, the "Veterans Traumatic Brain Injury Treatment Act." It is fair to say that traumatic brain injury (TBI) is considered the signature health crisis for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) veterans. We believe that the provisions of this legislation will enhance the ability of the VA to provide comprehensive care for veterans with TBI; however, we also have a couple of concerns with the legislation.

Proper screening for this newest generation of veterans is critical to their immediate and long-term care. Unofficial statistics suggest that many OEF/OIF veterans have suffered mild brain injuries that have gone undiagnosed. In many cases, symptoms have manifested themselves after

the veterans have returned home. The Department of Defense (DOD) admits that it lacks a system-wide approach for proper identification, management, and surveillance for individuals who sustain mild to moderate TBI. It is only appropriated that the VA be able to fill the gap left by DOD.

Furthermore, it will allow the VA to identify veterans who have experienced a TBI but whose symptoms have been masked by other conditions. We have heard anecdotally that this is a particular problem for veterans who have incurred a spinal cord injury in the upper cervical spine. Veterans who have incurred this level of injury as a result of a blast incident often have experienced a traumatic brain injury as well. However, their symptoms may be diagnosed as the result of their significant impairment at the cervical spinal level.

PVA certainly supports the need for a comprehensive long-term care program for veterans who have experienced TBI. The VA is the only real health care system in America capable of providing complex sustaining care over the life of the seriously disabled veteran. Private treatment options often give no consideration whatsoever to the long-term care needs of the veteran. Meanwhile, the VA has developed its long-term care program across the broad spectrum of services for many years.

However, we have some concern about the provision of this legislation that defines an eligible veteran as one who has served on active duty in a combat theater of operations. Recognizing that the vast majority of newly injured TBI veterans have experienced their injury as a result of combat service, this should not preclude the VA from providing long-term care services to any TBI veteran whose condition is service-connected.

PVA also is concerned about the provision within the section establishing TBI transition offices that further encourages cooperation with public and private entities. We understand that outside facilities and programs can bring some level of expertise to this population of veterans. However, we would hope that the VA would see fit to invest the majority of its resources in improving its own TBI programs, even as it taps into outside expertise. We urge the Congress, and VA, to proceed with caution as it looks to services provided outside of the VA health care system.

THE "VETERANS RURAL HEALTH CARE ACT"

PVA recognizes that there is no easy solution to meeting the needs of veterans who live in rural areas. These veterans were not originally the target population of men and women that the VA expected to treat. However, the VA decision to expand to an outpatient network through the community-based outpatient clinics reflected the growing demand on the VA system from veterans outside of typical urban or suburban settings.

PVA has no objection to the proposal to create two mobile Vet Centers. However, the one caution we would offer is that services provided in this manner tend to be more expensive and less cost-effective. I would suggest that mobile services tend to be much more cost-effective in areas where a large segment of the target population can be served because it drives down the

overall cost-per-patient. This implies that mobile centers would be best served in urban areas. However, we are willing to allow this pilot program to test the waters. We would suggest that the length of the program be shortened to three years or less so as to allow a sooner cost-benefit analysis of that program.

We fully support the creation of an Advisory Committee on Rural Veterans. We are particularly pleased that the legislation includes a provision for veterans service organization representation; however, we believe that more than one voice should be included. While the proposal includes the Secretary of Health and Human Services and the Director of the Indian Health Service as ex officio members of the committee, we believe that the Department of Defense Under Secretary for Personnel and Readiness or the Assistant Secretary of Defense for Health Affairs should also be included. This committee could provide well-researched and reasonably considered alternatives for rural health care.

We also support the creation of rural health research, education, and clinical care centers. These centers would essentially serve as centers-of-excellence for rural health care. This could allow the VA to address the needs of rural veterans through broad application of the "hub-and-spoke" principle. This is the same structure utilized in the spinal cord injury service. A veteran can get his or her basic care at a community-based outpatient clinic (spoke). However, if the veteran requires more intensive care or a special procedure, he or she can then be referred to the larger rural research, education, and clinical care center (hub). This would ensure that the veteran continues to get the best quality care provided directly by the VA, thereby maintaining the viability of the system. It will also allow the VA to develop excellence within the actual VA health care system, instead of farming out these services to the private sector.

Mr. Chairman and members of the Subcommittee, we recognize that the challenges the VA faces in the health care arena are difficult. However, we must reiterate that the VA will struggle to meet the ever-growing demand of veterans, particularly rural veterans, as long as it does not receive adequate resources in a timely manner. It is unreasonable, and frankly unacceptable, to place expectations on VA to meet certain types of demand, if it is not given the resources and tools necessary. Furthermore, allowing the VA to send veterans out into the private sector for care will absolutely not be the most cost-effective approach, nor will it allow veterans to get the best quality of care.

We look forward to working with the Subcommittee to develop workable solutions that will allow veterans to get the best quality care available. I would like to thank you again for allowing us to testify on these important measures. I would be happy to answer any questions that you might have.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2006

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $244,611 (estimated).

Fiscal Year 2005

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $193,019.

Paralyzed Veterans of America Outdoor Recreation Heritage Fund – Department of Defense – $1,000,000.

Fiscal Year 2004

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $246,541.

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Carl Blake is the National Legislative Director for Paralyzed Veterans of America (PVA) at PVA's National Office in Washington, D.C. He is responsible for the planning, coordination, and implementation of PVA's relations with the United States Congress and federal departments and agencies. He develops and executes PVA's Washington agenda in areas of budget, appropriations, health care, and veterans' benefits issues. He also represents PVA to federal agencies including the Department of Defense, Department of Labor, Small Business Administration, and the Office of Personnel Management.

Carl was raised in Woodford, Virginia. He attended the United States Military Academy at West Point, New York. He received a Bachelor of Science Degree from the Military Academy in May 1998.

Upon graduation from the Military Academy, he was commissioned as a Second Lieutenant in the Infantry in the United States Army. He was assigned to the 504th Parachute Infantry Regiment (1st Brigade) of the 82nd Airborne Division at Fort Bragg, North Carolina. He graduated from Infantry Officer Basic Course, U.S. Army Ranger School, U.S. Army Airborne School, and Air Assault School. His awards include the Army Commendation Medal, Expert Infantryman's Badge, and German Parachutist Badge. Carl retired from the military in October 2000 due to injuries suffered during a parachute operation.

Carl is a member of the Virginia-Mid-Atlantic chapter of the Paralyzed Veterans of America.

Carl lives in Fredericksburg, Virginia with his wife Venus, son Jonathan and daughter Brooke.